DEPARTMENT OF GENERAL SERVICES-STATE RECORDS CENTER

SCHEDULE NUMBER 2263

RECORDS RETENTION AND DISPOSAL SCHEDULE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PUBLIC HEALTH SERVICES (Secretariat) - FAMILY HEALTH ADMINISTRATION (Program)

This schedule supersedes schedules 856A, 950, 956A2, 1115, 1141, 1419, 1419-A1, 1420, 1760, 1759,and 1958.

The Family Health Administration (FHA) was created from the former Community and Public Health Administration (CPHA) on July 1, 2001. The Family Health Administration works to improve the health status of individuals and families by ensuring the provision of high quality primary, preventive and specialty care services. This schedule is organized functionally, by each component of the Administration.

Item	Description of Records Series (from Inventory Form)	Authorized Retention Period & Instructions
1.	**CENTER FOR CANCER SURVEILLANCE & CONTROL**	
	A. BREAST & CERVICAL CANCER SCREENING PROGRAM AND DIAGNOSIS & TREATMENT PROGRAM	
	1. These files contain patient records of program applications, biopsy results, operative results, PAP tests, mammograms, clinical breast examinations and other records related to prescribed screening, diagnosis and treatment of MD patients.	**Retain for ten (10) years,** then destroy.
	2. These files contain patient records of bills processed for breast and cervical cancer screening, and for diagnosis and treatment of MD patients.	**Retain for six (6) years,** then destroy.
	3. These files contain reimbursement records for the diagnosis and treatment of MD patients.	**Retain for ten (10) years,** then destroy.
	B. MARYLAND CANCER REGISTRY	
	1. Patient information on cancer, benign brain, and CNS tumor incidence and mortality, demographics, diagnosis, staging, operative results, vital status and other data.	**Retain for five (5) years,** then destroy.
	2. **Electronic records (Master Database).**	**Retain permanently**. Periodically transfer to Archives.
	C. CANCER PREVENTION, EDUCATION, SCREENING, AND TREATMENT PROGRAM (CRFP)	
	1. Patient records of screening, diagnosis and treatment, program notes, biopsy results, operative results, medical bills, and other records related to the prescribed diagnosis and treatment.	Screen annually. Discard material that is no longer needed.
	2. **CFRP DATABASE** (Electronic Master Database).	**Retain permanently**. Periodically transfer to Archives.

APPROVED BY DHMH OFFICIAL: DATE: 01/30/03

SIGNATURE: R Moy

NAME/TITLE: DR. RUSSELL MOY, DIRECTOR, FHA

AUTHORIZED BY STATE ARCHIVES: DATE: FEB 27 2003

SIGNATURE: Edward C. Papenfuse

NAME/TITLE: EDWARD PAPENFUSE, JR., STATE ARCHIVIST

DEPARTMENT OF HEALTH & MENTAL HYGIENE
PUBLIC HEALTH SERVICES – FAMILY HEALTH ADMINISTRATION

Secretariat Program

Item No.	Description of Records Series (Program, forms, etc.)	Authorized Retention Period/Instructions
2.	**<u>The Office for Genetics and Children with Special Health Care Needs</u>** (formerly Children's Medical Services and Hereditary Disorders.)	
	A. METABOLIC NUTRITION PROGRAM File series includes the following records: 1. lab reports; 2. clinic visits/ reports; 3. test results; and 4. general correspondence.	Screen file annually. Non-record material may be discarded and information that is obsolete or no longer needed may be removed to inactive files; send inactive files that are five (5) years old to record center; hold in record center twenty (20) years, then destroy.
	B. CHILDREN'S MEDICAL SERVICES File series includes the following records: 1. eligibility application (interview); 2. medical and nursing records; 3. physician's request for clinic consultations; 4. correspondence and memos; 5. authorization for service; 6. case mangement reports; and 7. any other pertinent Children's Medical Services case file data 8. transmittal payments:invoices, encumberances, other reports re services, provided to CMS children. 9. list of children dropped from CMS history list 10. payment vouchers/ reports 11. audit trail letters: letters sent to parents to verify services were actually provided that CMS paid.	Retain records of clients under age twenty-two (22) until ten (10) years after the last notation in the file, or until age twenty-four which ever is longer, then destroy (shred). Records may be sent to State Records Center for storage when no longer needed in office. Retain for six (6) years or until audited which ever is longer, then destroy. Send to State Records Center after audit for remainder of the six (6) years except when retention is less than eighteen (18) months.
	C. UNIVERSAL NEWBORN SCREENING File series includes the following records: 1. test results 2. related correspondence	Retain forms of children below age twenty-four (24) for eight (8) years, then destroy. Records may be sent to State Records Center for storage.
	D. SENTINEL BIRTH DEFECTS PROGRAM File series includes the following records: 1. sentinal birth defect form 2. related correspondence	Retain forms of children below age twenty-four (24) for eight (8) years, then destroy. Records may be sent to Records Center for storage.

DEPARTMENT OF HEALTH & MENTAL HYGIENE
PUBLIC HEALTH SERVICES – FAMILY HEALTH ADMINISTRATION

Secretariat Program

Item No.	Description of Records Series (Program, forms, etc.)	Authorized Retention Period/Instructions
3	**OFFICE OF PRIMARY CARE AND RURAL HEALTH**	
	A. Contracts, Grants, Mini-grants, and Unified Grant Awards	Retain completed contracts in office for five (5) years or until audit requirements are met, then destroy.
	B. Provider Applications and Updates.	Screen annually. Destroy outdated information. Retain original application in file until replaced by an updated, complete application.
	C. Provider agreements, Security ID Agreements	Retain for five (5) years or until audit requirements are met, then destroy.
	D. Patient Intake Forms	Destroy forms initiated before November 1999. Forms initiated after November 1999 are to be evaluated, and if appropriate, entered into the MPC database, then destroyed.
	E. Quality Assurance Audit Reports	Retain for five (5) years and then destroy.
	F. Primary Care Visit Reports	Retain for three (3) years and then destroy.
	G. Active Physician Files	Screen annually. Destroy files no longer active after five (5) years.
	H. Community Health Center Files	Screen annually. Destroy information that is obsolete or no longer needed.
	I. FMIS runs-backup data for Medicare/Medicaid appeals.	Retain until appeals are settled, then destroy with approval of Home Health accountant.
	J. Medicare and Medicaid cost reports and back- up materials.	Retain for five (5) years after cost reports are settled, then destroy.
	K. Maryland Primary Care Database	Retain permanently. Periodically transfer to Archives.